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NCAB HEEDS BLOCH'S PLEA, TO CONSIDER ESTABLISHING SEPARATE PDQ-LIKE SYSTEM FOR GENERAL PUBLIC USE

Richard Bloch's persistence in his conviction that the country's nononcologic medical practitioners should be pressured into seeking information on the latest and best methods of diagnosing and treating

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In Brief

EARL POLLACK TO RETIRE AS HEAD OF SEER PROGRAM; NURSING FOUNDATION, LEDERLE OFFER SCHOLARSHIPS

EARL POLLACK, who headed up the reorganization of NCI's Surveillance, Epidemiology & End Results (SEER) Program starting in 1977 when he came to NCI from the National Institute of Mental Health, will retire from his position as chief of the Biometry Branch Jan. 2. SEER is now considered one of NCI's most successful programs. Pollack, who has 33 years of federal service, plans to do consulting in the health field.... **ROBERT MCKENNA,** immediate past president of the Society of Surgical Oncology and clinical professor of surgery at the Univ. of Southern California, is not a medical oncologist, as he was identified in **The Cancer Letter** item noting his election as president of the American Cancer Society (Nov. 23 issue). McKenna is in private practice as a surgical oncologist with the Wilshire Oncology Medical Group in Southern California.... **ONCOLOGY NURSING** Foundation, established in 1982 by the Oncology Nursing Society, has initiated the Oncology Nursing Foundation/Lederle Undergraduate Scholarship Program. With financial support from Lederle Laboratories, the Foundation will award $1,000 scholarships to five registered nurses pursuing bachelor of science degrees in nursing. Criteria and applications may be obtained from the Oncology Nursing Foundation, 3111 Banksville Rd., Suite 200, Pittsburgh, Pa. 15216, phone 412-344-3899.... **Litton Institute** of Applied Biotechnology and the Univ. of Texas Health Sciences Center in San Antonio have developed a sensitive and specific immunoassay procedure using a monoclonal antibody to identify and monitor a bladder cancer marker in urine. The work is described by Richard McCabe and Donald Lamm in the December issue of "Cancer Research".... **HOWARD STOLL** has been appointed chief of the Dematology Section at Roswell Park memorial Institute. Stoll has been affiliated with the Dermatology Dept. there since 1958 and has been associatec chief since 1968.... **ANNUAL REPORT** for 1983 of the Council for Tobacco Research includes abstracts of 185 scientific publications, the largest number in any year since the Council was established in 1954 by tobacco manufacturers, growers and warehousemen. The Council said it has provided more than $83 million to 497 scientists since 1954, supporting 865 research projects. Awards are made on recommendations of an independent peer review group.

NCAB TO CONSIDER DEVELOPING NEW PDQ SYSTEM FOR PROMOTION TO THE PUBLIC

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cancer may lead to establishing a new computer based system aimed at making that information available to the general public. Bloch's impassioned plea last week to his fellow National Cancer Advisory Board members convinced the Board to at least consider developing a new system along the lines of but separate from NCI's PDQ, which at present is pretty much limited to physicians and other health professionals.

PDQ was Bloch's idea from the start, and he contributed several hundred thousand dollars toward the purchase of the building adjacent to the NIH campus where PDQ staff members and other components of NCI's International Cancer Information Center are housed. This and other contributions by Bloch to the fight against cancer were motivated by his personal experience with lung cancer. Bloch eventually was successfully treated, but not until after first being misdiagnosed and then told that he had no chance of survival. He is convinced that his experience is not atypical and that a major effort is needed to raise the level of physician competence in dealing with cancer.

Bloch came up with the idea of putting state of the art information in a system that would allow easy access by personal computers, which most medical offices now have. He sold NCI Director Vincent DeVita on the idea, and PDQ is the result. However, along the line opposition developed from a number of sources, and DeVita was pressured into agreeing that PDQ would be limited to professionals. The NCAB specifically rejected Bloch's earlier plea that PDQ be designed for and heavily publicized to the public, supporting the position of the American Medical Assn. and other organizations.

Bloch agrees that PDQ as it exists now is an excellent resource, containing details on state of the art, accepted standard treatment as well as on current clinical protocols, with names, addresses and phone numbers of principal investigators. It also includes names and addresses of members of the professional oncologic societies and other physicians who consider themselves cancer specialists.

However, NCI in negotiating with computer utility vendors for PDQ distribution has insisted that they may promote the service only to health professionals. Bloch is convinced that physicians in general will not use the service unless pressured to do so by their patients. In his appeal to the NCAB, Bloch read a letter he had previously sent members:

"I am . . . asking your consideration of three items I trust will be brought up at the next NCAB meeting. Personally, I do not like to be asked to render an opinion on the spur of the moment on an important issue where it would have been possible to study and weigh the matter. Therefore, I would like to see brought up what I conceive are three separate issues.

"First is the suggestion that the list of physicians be separated from PDQ and made an individual program. There is no doubt that the list of physicians is an excellent idea that has many applications. As Dr. DeVita has stated, it is one of the most interesting parts of PDQ. However, it has been found offensive or objectionable by the AMA and others. So much so that they are opposed to the entire program. By removing all names from PDQ, it would appear that these objections would be satisfied and the promotion and use of PDQ could get back on track. These names could be put in another program and available any way desirable, or as they have been for years, through CIS.

"Second is that publicity of PDQ be directed at the entire population as well as physicians. Bear in mind that PDQ is only a more concise and current reference book. The quality physician who practices state of the art therapy will find the proper sources of information with or without PDQ. The less than current practitioner, the one who already knows there is no possible treatment for this particular stage, is the one who must not only be made aware of PDQ's existence, but must be made to take extra effort to accept it and study it. To publicize PDQ to the physicians who need it the most is like advertising in a newspaper a course in reading for illiterates.

"We heard all the arguments on why the medical community had to be aware of the program first. I agreed. I understood how irritating it could be for a doctor to learn about this wonderful resource from a patient or the press. That was one year ago. On page 12 of the book entitled, 'National Cancer Program,' dated Sept. 15, 1984, that we received at the last meeting, it states, 'If physicians avail themselves of the opportunity now offered by PDQ, NCI estimates that national survival rates would rise by at least 10 per cent, or more than 40,000 lives saved per year.' This is more than 100 American lives every single day. We have been shown the flyers that have been sent out to the medical community. I was told at the President's Cancer Panel in San Francisco and again in Bethesda about all the superb articles and publicity it has received in medical trade publications. All right, I think one year is enough time to advise the medical community at the price of 100 human beings per day. Now let's get NBC and CBS and ABC and UPI and AP to do the job and saves the lives that can be saved now.

"Third would be to make this available to any vendors without any strings, or relatively no strings. We should stay out of trying to tell private enterprise how to run their business. A year and a half ago we had numerous vendors who were anxious to distribute PDQ. Compuserve, the one I know the best because H & R Block owns it, wanted to do it as a public service. By the way, I resigned from the company and sold my stock so that no one could say I was promoting PDQ for my personal benefit. I read those licensing agreements. We must have spent a great deal on legal fees because we tied those people up in little knots if they would have signed. Obviously we lost them all except one company that I have never heard of and that I do not believe has their own network of private lines to be locally accessible to the average community physician.

"I would like to see the privilege to dispense this knowledge given without charge. Actually, we should pay the providers for doing our job, but I do not believe that is necessary. Second, do not put any strings on how they can arrange the information. Do we think we have all the brains in the world? These are successful business people and they know they must provide a quality product or they would not be in business. PDQ, without the list of doctors, is nothing more than a concise, current textbook. Don't saddle a private vendor with unreasonable restrictions as to who may look into this book.

"A vendor should ascertain that the user is a physician only if the names of doctors or details of protocols are given. To say that the treatment of choice is surgery followed by radiation, or that the response rate on CMF is 40 per cent and on MOPP is 30 per cent should not be classified information and withheld from anyone. Also the names of institutions offering current protocols for specific tumors must be accessible to everyone.

"In actual practice and the reason I never had any concern about making PDQ available only to physicians is that I do not believe a patient would have the medical knowledge to properly put the information in to get the answers in the way the system was conceived. Very few patients I have ever met know their type of cell, how well differentiated it is, the stage of their disease, the extent of metastasis, and what other medical factors there are in their history that have bearing on their treatment. Furthermore, it was never my intention, nor would I believe it would be of any practical value, to explain the details of any experimental protocol. It would only give the names of the institutions and describe the type of therapy in the protocols and statistics, not the details. As Dr. DeVita has said, cancer patients should look for for those who have had the most experience.

"The fantastic job NCI has done in amassing this enormous volume of knowledge is awesome. The teamwork demonstrated by the entire staff in accomplishing this feat has been above and beyond. Now, let's get on with the job of reducing the morbidity and mortality of cancer, as the Act directed us."

DeVita expressed sympathy for Bloch's view. "One of the first questions we asked was if the system should be made available to the public," he said. "It is a sensitive issue. This Board decided that it is a medical system and should be made available only to professionals, that it not be a self referral system. We followed the Board's advice. Personaly, I am not opposed to making this available to the public. It is true that much of it is medically oriented and not usable by the public."

DeVita pointed out the directories of members of the various societies may be available from other sources. He took issue with Bloch on permitting vendors unrestricted use of the data base. "We're not in a position to let vendors do anything they want with the information. We're responsible for the elements included, such as doses and schedules."

DeVita resisted the suggestion that PDQ be substantially changed at this time. "I have a very strong feeling about that. PDQ is up, its use is just getting started, and it has not been evaluated, although we are providing for evaluation." On negotiations with Compuserve, "I don't believe Compuserve really wanted PDQ as it is. B.F. Saunders (the vendor which has agreed to offer PDQ to professionals) is not unknown. . . The issue is whether the system should be made available to the public through a vendor. If we would agree to that, we could have a big vendor tomorrow."

Bloch related some horrow stories he has heard which he said demonstrates the need for wider distribution of PDQ: "The man who was treated with BCG for lung cancer. The lady who was told she was cured of breast cancer because only five of 16 lymph nodes were positive. The young woman who had a double mastectomy, only to be told the next day the lumps were not malignant; she later committed suicide. Most doctors say that pancreatic cancer is terminal, yet PDQ has over 200 protocols for pancreatic cancer. Why can't a pancreatic cancer patient consider that he could be among the two per cent who will survive, instead of staying home waiting to die?"

NCAB Chairman David Korn commented, "The question is whether or not there should be a system of information for distribution to the public. Is this a concept for the Board to consider? Something different than PDQ?"

Board member Enrico Mihich backed that

suggestion. "What you are proposing is a doctor alert system, different from PDQ. The idea to consider another system is perfectly all right to discuss, but only when the full Board is present." Bloch's appeal was made on the final day of the meeting, after half the members had already departed.

"Getting the word out to the public is not as simple as you may think," Board member Rose Kushner said. "Most newspapers have had stories on PDQ, without much impact. What is needed is to put out public service announcements by the director, repeatedly."

"If we're going to talk about another system, we need a group to work on it," Board member Helene Brown said.

Korn suggested that "the first job of the (Board's) Committee on Information should be to put together a presentation to the Board on current resources for disseminating information, develop suggestions on ways that it might be improved, including perhaps a recommendation for a new system."

"That's an excellent suggestion except for one factor," Bloch said. "During the last year, when the Board met four times, survival increased one per cent. According to NCI, in one fell swoop, we could increase survival 10 per cent (with full use of PDQ). NCI has information it won't give to the public. I don't want to be a party to this."

"I think there is a misunderstanding," Board member Geza Jako said. "I don't know where you get that information, that NCI has information it will not give out."

Bloch said that refusing to permit nonprofessional access to PDQ constitutes withholding information from the public. He offered another suggestion for encouraging physician use of PDQ: "If we would pay every doctor $100 everytime he used PDQ, everyone would, and we would save 40,000 lives a year."

"If I believed that would happen, we would do it," DeVita said. He also pointed out that the Office of Cancer Communications supports a variety of information programs for professionals and the public which disseminates much of the information included in PDQ "in other ways." He noted that a major effort would be launched in January to promote the availability of PDQ through the vendor.

A motion by Board member William Powers that the Committee on Information be directed to meet prior to the next meeting of the full Board to consider the issue was approved unanimously.

Powers brought up a letter he had sent to DeVita listing a number of discrepancies in PDQ's listing of radiotherapists in Michigan. Susan Hubbard, director of the International Cancer Information Center, responded with a variety of reasons for the discrepancies, most of them familiar to anyone with experience in compiling mailing lists. "It will be a great challenge to NCI staff to maintain and verify this list," Hubbard said.

NCI PAYLINE IN 1985 LIKELY TO BE 170; $5.9 MILLION DIVERTED TO AIDS

NCI was able to fund 969 competing research project grants (RO1s and PO1s) in the 1984 fiscal year, exceeding the original estimate of 923 and helping NIH go over the goal of supporting 5,000 new and competing renewal grants. The total for NIH in the year was 5,497.

NCI Director Vincent DeVita told the National Cancer Advisory Board last week that the payline for RO1s in 1984 was 175 priority score, 178 for PO1s. NCI funded 38.7 per cent of approved competing grants, at a cost of $157.6 million.

In the current, 1985 fiscal year, DeVita said NCI hoped to fund 1,030 competing grants, which would be about 37 per cent of those approved. The payline may drop to as low as 170 for both RO1s and PO1s, DeVita said, although $175.8 million is available for funding those grants.

The total number of grants NCI supports could be reduced with the first Outstanding Investigator Awards which will be made during 1985, DeVita pointed out. OIA grants will have the effect of consolidating an investigator's RO1s into the new mechanism. The total number of dollars will not be affected.

Failure of Congress to direct any of the additional money it voted for AIDS related projects to NCI has posed a severe problem for the NCI 1985 budget. HHS has directed that NCI reprogram $5.9 million from other areas for AIDS research. Here is where that money will come from:

$3 million from the RO1-PO1 pool; $1 million from cancer center core grants; $600,000 from the Research Career Program; $300,000 from the Clinical Education Program; and $1 million from clinical cooperative groups. Of the $5.9 million, $4.8 million will go to AIDS related R & D contracts, and $1.1 million to intramural research.

In 1984, NCI supported $6.6 million in AIDS grants, $5 million in AIDS contracts, and $5 million for intramural research on AIDS. In 1985, those figures will increase to $10.7 million in grants, $9 million in contracts, and $7 million for intramural research. Those include the reprogrammed $5.9 million.

The NCAB and other NCI advisory bodies are still bitter that NCI was left out of the amendment by Sen. Alan Cranston (D.-Calif.) which added $14 million for AIDS but gave none of that to NCI.

"We've been corresponding with Sen. Crantson," DeVita said. "There was no malice against us, no

no intent to leave NCI out. I just don't think it is very well known that NCI has done about 40 per cent of the AIDS research."

NCAB COMMITTEE APPROVES CONCEPTS FOR NEW, RECOMPETING OD CONTRACTS

The National Cancer Advisory Board Committee for Review of Contracts & Budget of the NCI Office of the Director gave concept approval to one new contract for a study of office automation and to the recompetition of three existing contracts, the four totaling an estimated $9.3 million over the life of the awards, at the Board's meeting last week.

The committee also approved the concept of renewing for five years the interagency agreement with the National Technical Information Service for its services to the International Cancer Research Data Bank, at an estimated cost of $3.9 million; and a noncompetitive extension of the contract for cancer communications program support with Nancy Low & Associates, at an estimated cost of $600,000.

The committee deferred until the Board's February meeting a decision on recompeting the management information systems support contract with Systems Science Inc. The new five year contract would cost an estimated $1.2 million, and committee members felt they needed more information than was provided.

Staff description and justification of the new and recompeting contract supported projects:

Title: Office automation study/management. The committee approved this new contract, to be awarded for three years with an estimated cost of $500,000. This was trimmed from the staff's recommendation for a five year award to total $1.3 million.

The contractor will be expected to perform an NCI requirements assessment, and a technology assessment, perform a cost benefit analysis, develop a concept of operations, develop alternative strategy options, define implementation tasks, prepare an implementation schedule, prepare technical specifications, monitor implementation, validate system performance and confirm productivity improvements.

Edwin Odisho is the project officer.

Title: Programming and systems maintenance in support of the NCI contracts management system. This is a recompetition of a contract presently held by General Software Corp. The committee approved a three year award rather than five as requested by staff and trimmed the total estimated cost from $1.3 million to $710,000. The committee also asked that the project be brought back for reconfirmation after one year.

Under the guidance of the Extramural Financial Data Branch, the contractor is responsible for the overall functioning of the contracts management system and its two subsystems, the preaward tracking system and the contracts administration system. The three systems are collectively known as the contracts management system which is a management tool used in disseminating administrative, fiscal and planning data.

Robert Spallone is the project officer.

Title: Service for the Div. of Extramural Activities and the Grants Administration and Extramural Financial Data branches of the Office of the Director. This is a recompetition of a contract presently held by Prospect Associates. The committee approved a six year award at an estimated cost of $2 million.

The proposed services would enable DEA and the two branches of OD to respond to intermittent and dynamic situations/tasks which require the mobilization and concentration of a variety of specialized resources without adversely impacting daily operations. These dynamic situations require directed shifts in priorities which are not ideally suited to an established workforce nor require permanent manpower recruitment.

In addition to procuring highly specialized technical skills, the proposed contract would provide flexibility in staffing of clerical support, office equipment and space needed to perform high priority one shot tasks having rapid turnaround requirements. Having access to this type of capability alleviates the need and resulting backlog of having to divert existing staff from ongoing duties.

Leo Buscher is the project officer.

Title: Cancer communications program support. This is a recompetition of a contract currently held by Nancy Low & Associates. The committee approved an award of five years at an estimated cost of $6.1 million.

The National Cancer Act and its amendments require that the "director of the National Cancer Institute shall provide and contract for a program to disseminate and interpret on a current basis, for practitioners and other health professionals, scientists and the general public, scientific and other information respecting the cause, prevention, diagnosis and treatment of cancer."

Since 1978, the Office of Cancer Communications has required contract services to assist in the development and implementation of communication and education programs on prevention, diagnosis and treatment. This support is needed to develop, implement and evaluate the broadscale public information program of OCC which includes the prevention awareness program, coping with cancer, education efforts targeted to minorities, breast cancer education and PDQ development. The contractor provides technical support services to create and implement such programs and to improve communications approaches and techniques for motivating both the public and health professionals to take the necessary steps which would help:

*Decrease exposure of individuals and groups to cancer risks.

*Increase the use of early cancer detection techniques.

*Increase the use of improved diagnostic, treatment and rehabilitation programs.

Rose Mary Romano is the project officer.

RFA 85-CA-02
Title: Interinstitutional network for automated flow cytometry research in the diagnosis and treatment of urinary bladder cancer
Application receipt date: Jan. 11

The Div. of Cancer Prevention & Control of NCI invites cooperative agreement applications for participation in an interinstitutional flow cytometry network for research in urinary bladder cancer. The major goal of this RFA is to encourage rapid development of a state of the art flow cytometry network to serve the diagnostic and treatment needs of bladder cancer patients. The proposed network of collaborating laboratories will evolve optimum methods for identifying bladder cancer through steps of technique modification and refinement. Flow cytometry will be evaluated for detecting tumor recurrence in bladder cancer patients who are receiving chemical, radiation or immunotherapy, and for monitoring symptomatic patients and high risk populations.

The principal investigators in the network will have primary responsibility for planning, directing and evaluating research in conjunction with an active participation by the DCPC program staff throughout the course of the study. DCPC staff will periodically evaluate research priorities and review progress to ensure that the network conforms to the objectives and conditions of the award.

The intent of the RFA is to initiate interinstitutional clinical studies of the urinary bladder among flow cytometry laboratories which are already contributing to cancer research. The required technical expertise, facilities and resources should already exist in an applicant institution which responds to the RFA.

An applicant institution may apply for a period of support of up to three years under the RFA. A maximum of five awards will be made. Such awards will support only interinstitutional aspects of the research program. Core support for bladder cancer flow cytometry at the applicant institution must be fully funded through alternative mechanisms. This type of RFA is used when NCI, with concurrence of a board of scientific counselors, wishes to stimulate investigator interest, proposes to assist in research planning, and intends to monitor investigator progress in an important and opportune area of research.

Form PHS-398 (revised 5/82) should be used, which is the application form for the traditional research project grant. It is available in the business and grant/contract offices of most academic and research institutions, or from the Div. of Research Grants, NIH, Bethesda, Md. 20205. The original and six copies of the application should be delivered to DRG at that address by the deadline above. Copies of the complete RFA and further information are available from William Straile, PhD, Cancer Centers Branch, DCPC, NCI, Blair Bldg Rm 727, Bethesda 20205, phone 301-427-8818.

RFA 85-CA-03
Title: Cytogenetics and predisposition to cancer
Application receipt date: March 15

The Div. of Cancer Biology & Diagnosis of NCI is inviting grant applications from interested investigators to determine whether certain sites on chromosomes can be identified as predisposing factors in human cancer. Recent research in cytogenetics has indicated that there may be significant correlations between certain nonrandom chromosomal aberrations and particular types of cancer. Improved techniques for eliciting and examining these alterations in human chromosomes have contributed to the development of a small but growing body of data which supports the potential importance of cytogenetic analysis to the early detection, diagnosis and prognosis of cancer. Considerably more data are necessary in order to confirm the importance of these observations.

This type of solicitation is being used to encourage investigator initiated research projects studying nonrandom identifiable chromosomal sites and to focus this research on the relationship of these sites to cancer. This is an area of special importance to the National Cancer Program.

Significant progress has been made in the ability to elicit and identify fragile sites. In order to maximize the opportunities to identify additional nonrandom chromosomal sites which might be significant in cancer, more research must be done to improve the techniques for eliciting such sites and for fine structure analysis of chromosomes. The hereditary pattern of new sites must be established. Studies must be designed to determine whether the known sites and newly discovered ones act as predisposing factors in human cancer. The purpose of this RFA is to encourage applications directed toward development of new techniques and toward testing the hypothesis of the relationship between fragile sites and other identifiable nonrandom sites and cancer. It is hoped that suitable collaborations will be developed between clinicans with access to appropriate patient populations and basic scientists involved in cytogenetic research.

The support mechanism for this program will be the traditional NIH grant in aid. Applicants will plan and execute their own programs. Approximately $625,000 will be set aside to specifically fund applications which are submitted in response to this RFA. It is anticipated that four to five applications can be funded. These applications will not compete for funding within the general pool of dollars available for other investigator initiated research proposals. However, all applications will be evaluated by the rigorous standards of study section review. The expected starting date is Dec. 1, 1985.

A copy of the complete RFA and further information may be obtained from Sheila Taube, PhD, Chief, Biochemical Diagnosis Section, DCBD, NCI, Westwood Bldg Rm 10A15, Bethesda 20205, phone 301-496-7147.

RFA 85-CA-04
Title: Continuing care research: identifying and reducing obstacles for cancer patients
Application receipt date: Jan. 8

The Div. of Cancer Prevention & Control of NCI invites applications for research projects which

address the various concrete problems that confront patients and/or their families. This initiative encourages studies that seek ways to facilitate the resolution of these problems. As a first step, investigators will establish the incidence and prevalence of concrete problems found in their cancer care setting. They will estimate the extent and efficacy with which available resources or services have solved these problems. Following an analysis of these data, a second step will involve implementation of programs aimed at resolving the obstacles that contribute to such problems. The awardees will individually prioritize these needs and design specific interventions based on local needs or demands and available resources and personnel. The proposed research effort will be divided into the following stages:

A. Descriptive studies. Perform prospective surveys, using a common instrument and set of definitions, to determine the incidence and prevalence of resolved and unresolved concrete problems. The description should include information related to site and stage of disease and functional status of the patient. Characterize the efficiency and effectiveness of existing mechanisms for the resolution of concrete problems. Develop a predictive model for practical interventions.

B. Implementation program. Implement a program consisting of evaluable interventions aimed at maximizing resolution of concrete problems. Evaluate the predictive model and the efficacy of the interventions.

Applications funded under this RFA will be supported through the cooperative agreement mechanism. NCI anticipates making six awards, each for a period of four years. A total of $300,000 has been site aside to fund the direct costs of the awards for the initial year.

Copies of the RFA and additional information may be obtained from Wilma Dunlap, Community Outreach & Rehabilitation Branch, Centers & Community Oncology Program, DCPC, NCI, Blair Bldg Rm 7A05, Bethesda 20205, phone 301-427-8708.

RFA 85-CA-05
Title: Cancer control small grants research program
Application receipt date: Feb. 12

The Div. of Cancer Prevention & Control of NCI invites small grants research applications from investigators who meet the eligibility criteria noted below. This RFA is a reissuance of RFA 84-CA-07.

Cancer control small grants research is designed to encourage scientists from a variety of academic disciplines to apply their skills to scientific investigations in the field of human cancer control intervention research.

Cancer control is defined as the reduction of cancer incidence, morbidity and mortality through an orderly sequence from research on interventions and their impact in defined populations to the broad, systematic application of the research results.

Cancer control research studies are classified into one of five phases which represent the orderly progression noted in the above definition: (1) hypothesis development; (2) methods development and testing; (3) controlled intervention trials to establish cause and effect relationships; (4) research in defined, human populations; (5) demonstration and implementation studies. DCPC is primarily interested in research on interventions phase 2 through 5.

Cancer control program areas appropriate for research grants include human intervention research in prevention (chemoprevention, diet and nutrition, occupation, and early detection), community oncology (improving application of patient management and continuing care research advances in community settings), and health promotion sciences (modifying personal, social and lifestyle and health care system factors which contribute to cancer prevention and control).

These cancer control studies may also include applied epidemiology studies, which attempt to use epidemiologic methods to determine the association between exposure to an intervention and its impact on disease; epidemiologic, planning and survey, studies aimed at developing cancer control interventions could also be included.

Studies to determine the efficacy of chemotherapy, surgery, radiotherapy and other primary treatment interventions are not considered cancer control research under this RFA.

Investigators are eligible to apply for a small grant to support research on a cancer control topic if they are interested in conducting exploratory studies in cancer control research and have never received NCI cancer control funding. This includes established researchers from other disciplines, new investigators and investigators currently enrolled in an accredited doctoral degree program; however, it excludes individuals who have ever been a principal or coprincipal investigator on an NCI funded cancer control grant or contract, or a paid staff member on an NCI funded grant or contract for more than one year.

If the research will constitute a doctoral dissertation, a written statement from the applicant's dissertation chairperson or equivalent academic supervisor that the project proposal has his/her approval must accompany the application; if the study is selected for support under this program, a statement of approval of the full dissertation committee is required before funding will be made.

The mechanism of support is the NIH grant in aid. Total costs (direct plus indirect costs) must not exceed $35,000. The duration of support is one year but may be longer (up to two years) if the funding limits noted above are not exceeded. The direct costs for dissertation research should not exceed $15,000.

Prospective applicants are strongly encouraged to discuss their ideas with the program director to determine whether they fit within the definition and program guidelines of cancer control. Applications which, in the opinion of NCI staff, do not fit will be returned without review.

Copies of the complete RFA and additional information may be obtained from Dr. Carlos Caban, Program Director, Cancer Control Applications

Branch, DCPC, NCI, Blair Bldg Rm 4A01, Bethesda 20205, phone 301-427-8735.

PROGRAM ANNOUNCEMENTS

Research on biological response modifiers
Application receipt dates: March 1, July 1, Nov. 1.

NCI's Div. of Cancer Treatment desires to expand its support for several areas of research dealing with biological response modifiers related to clinical treatment. Five areas of special interest are described below. Interested applicants are encouraged to contact NCI staff members listed for additional information.

In making this program announcement it is not the intent of NCI to make or imply any deliniation related to biological response modifier research, but rather to stimulate investigator initiated research in biological response modifiers.

Applications in response to this announcement will be reviewed in accordance with the usual NIH peer review procedures. The review criteria customarily employed by NIH for regular research grant applications will prevail.

Determination of the therapeutic usefulness of purified cytokines and anticytokine monoclonal antibodies in cancer models.

The Biological Response Modifiers Program is seeking applications for research grants concerned with the modes of action of purified cytokines in ways that will be relevant to determination of therapeutic potential through direct effects on certain types of malignant cells or on supportive tissue of tumors. Methods of regulating or manipulating the specific cytokine levels through utilization of purified cytokines and/or utilization of anticytokine monoclonal antibodies are of interest. Work with in vivo animal models would be particularly relevant.

Contact Dr. Gary Thurman, Program Director for Molecular Immunology, BRMP, DCT, NCI, Frederick Cancer Research Facility, Bldg 426 Rm 1, Frederick, Md. 21701, phone 301-695-1098.

Use of growth factors, maturation factors and antigrowth factors in animal tumor models.

The program is seeking applications for research grants concerned with the therapeutic effects of growth factors, maturation factors, and monoclonal antibody to growth factors on the growth and metastasis of cancer in animal tumor models.

Contact Dr. Cedric Long, Acting Chief, Biological Resources Branch, BRMP, DCT, NCI, FCRF, Bldg 426 Rm 1, Frederick, Md. 21701, phone 301-695-1098.

Use of tumor associated antigens as immunogens.

The program is seeking applications for research grants concerned with the development of methods of immunization that evoke effective in vivo antitumor immunity using purified tumor associated antigens as immunogens. Isolation of tumor associated antigens is now possible using monoclonal antibodies. There is considerable uncertainty, however, how best to administer purified antigens in vivo to evoke effective antitumor immunity. Certain antigens may facilitate and others may inhibit tumor growth and metastases. The proposed studies should investigate this issue in both normal and tumor bearing animals using purified antigens as therapeutic agents. Preference will be given to nonviral tumor associated antigens on recently derived spontaneous or chemically induced fully syngeneic tumors although consideration will be given to viral coded tumor antigens and even normal cell surface alloantigens as model antigens. The use of various immunization schedules and adjuvants in therapy models with detailed monitoring of host cellular and immune responses will be required. These studies must be directed toward optimizing the therapeutic effects of these antigens in vivo as demonstrated by protection studies against subsequent tumor growth. Proposals to investigate monoclonal antibody purified tumor associated antigens as therapeutic reagents in many may also be submitted. As in the animal models, homogenous preparations of high purity are preferred for these investigations. End points may be assessed by in vitro or by in vivo therapetuic effects.

Contact Cedric Long at the address given above.

Development of cell lines producing lymphokines and cytokines.

The program is seeking meritorious grant applications for research concerned with the development of cell lines and the development of methods to isolate, purify and characterize the therapeutic potential of the various products of these cell lines in appropriate test systems. These products may have a potential long term usefulness in the treatment of cancer and/or in the alteration of biological responses in the course of cancer.

Contact Cedric Long for more information.

Development of genetically engineered cell products.

The program is seeking applications for research grants concerned with the development of genetically engineered cell products for therapeutic application as biological response modifiers. This announcement will support diverse approaches into the use of genetic engineering to transpose genes coding for biological response modifiers such as interferons, lymphokines, growth factors and other gene products into microbial organisms for a large scale production, isolation, purification and characterization of these factors for therapeutic application as biological response modifiers.

Contact Cedric Long for further information.

The Cancer Letter _Editor Jerry D. Boyd

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